Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES J. KROGMEIER, DIRECTOR

December 14, 2009

The Honorable Chester J. Culver
Governor
State Capitol
LOCAL

Dear Governor Culver:

Enclosed please find a copy of the report to the General Assembly relative to the Act requiring the Departments of Public Health and Human Services to collect data and develop a protocol to address the relationship between substance misuse, abuse, or dependency by a child's parent, guardian, custodian, or other person responsible for the child's care and child abuse.

This report was prepared pursuant to the directive contained in House File 2310. The Departments of Public Health and Human Services conducted a study to identify an effective means of reducing the incidence and impact of child abuse, including denial of critical care and interventions with families by the child welfare system that is wholly or partially caused by substance misuse, abuse, or dependency by the child's caretaker (parent, guardian, custodian or other person responsible for the child's care). The study also identified potential changes in Iowa law that could encourage the child's caretaker to secure voluntary treatment for substance misuse, abuse, or dependency. Data identifying the prevalence of the presence of children in households among adults receiving substance use disorder evaluations was collected. Data identifying as to whether or not substance abuse by the child's caretaker was a factor in the report and finding of abuse was also collected. A protocol was developed and piloted to jointly address child abuse cases that are wholly or partially caused by substance misuse, abuse, or dependency by the child's caretaker.

If you would like any additional information about this report please feel free to contact me.

Sincerely,

Julie A. Fleming
Legislative Liaison

Enclosure

cc: Michael Marshall, Secretary Iowa Senate
Mark Brandsgard, Chief Clerk of the House

JAF:tb

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Secretary of Senate
State Capitol
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cc: Governor Chet Culver
Legislative Service Agency

Kris Bell, Senate Majority Caucus
Peter Matthes, Senate Minority Caucus
Zeke Furlong, House Majority Caucus
Brad Trow, House Minority Caucus

JAF:tb

House File 2310 Legislative Report

December 15, 2009

State of Iowa

Department of Human Services

&

Iowa Department of Public Health

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I. Introduction

Research and practical experience repeatedly show a high correlation between parental substance use disorders and child maltreatment and that many, if not most, children under the jurisdiction of child welfare agencies and the courts come from families with substance use disorders. National data reveals that up to 80% of adults associated with a child welfare case have a substance abuse problem that contributes to the abuse or neglect of the children.[1] In Iowa, 70-80% of open child welfare cases are related to substance abuse and 22% of clients receiving substance abuse services report a Department of Human Service (DHS) child welfare connection.

While substance use disorders are not the sole determinants of risk to children, many Iowa families involved with the child welfare agency have a substance abuse and related mental health problem. This correlation has implications for families, child welfare professionals, substance abuse treatment providers, and the judicial system as it requires initial and ongoing screening and assessment to identify possible substance use disorders. Indeed, best practice demands that all those involved with a child welfare-involved family work with the assumption that those disorders are likely to exist (i.e., best practice should be to "rule out" substance use disorders). Once identified, assessment of child safety and risk of child maltreatment within families receiving substance abuse services should occur on an ongoing basis.

II. Background

In Iowa, several statewide initiatives have begun to promote agency collaboration for families and children who are experiencing substance use disorders. In 2007 a statewide group of agencies and organizations involved in child welfare met and developed the Iowa Perinatal Illicit Drug Screening and Intervention Protocol that included a screening tool. This initiative was led by the University of Iowa Child Protection Program. Other professional organizations and/or groups involved included the Iowa Drug Endangered Children Alliance, Iowa Child Protection Council, the Iowa Perinatal Care Program, and the Iowa Departments of Human Services, Public Health, Child Protection Centers, and Iowa's Hospital Association. The protocol and the screening tool were approved by the Iowa Perinatal Care Program Advisory Board to be included in the Iowa Perinatal Care Guidelines. Since 2008, Iowa Perinatal Care Program staff has been disseminating this protocol and tool to birthing hospitals across Iowa that has led to a more consistent approach regarding perinatal illicit drug screening in Iowa hospitals. The 8th edition of the Guidelines for Perinatal Services is located at the following link: http://www.idph.state.ia.us/hpcdp/common/pdf/8th_edition_guidelines.pdf.

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[1] *Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services with Child Welfare*. Nancy K. Young, Ph.D., Sidney L. Gardner, M.PA. Prepared by Children and Family Futures, Inc. For the Substance Abuse and Mental Health Administration, Center for Substance Abuse Treatment, Technical Assistance Publication Series 27.

Another initiative began in November of 2007, when the Iowa Judicial Branch, the Iowa Department of Public Health (IDPH) and the Iowa Department of Human Services (DHS) established a partnership to address the needs of families and children who are at the intersection of the substance abuse, juvenile court and the child welfare systems. The Department of Public Health and the Department of Human Services recognized that child maltreatment is frequently associated with parental/caregiver substance use disorders and that no single agency has the resources or expertise to comprehensively respond to the needs of the parent/caregiver, the child or the family as a whole. A significant number of individuals and families in Iowa who are involved in the child welfare system and juvenile court and who have substance use disorders are being mutually, and often simultaneously, served by the two departments. The Departments and the Court acknowledge that procedures to provide integrated court oversight, substance abuse treatment, and child welfare services must be developed in order to address the complex needs of families who are involved in all three systems. The Departments and the Court also recognize that professionals and caregivers at both the state and community level need to develop a common knowledge base and shared values about child welfare, the juvenile court system and substance use disorders.

With the support of the National Center for Substance Abuse and Child Welfare (NCSACW) through its In-Depth Technical Assistance (IDTA) initiative and a wide array of statewide stakeholders, a partnership was formed to enhance the capacity of the three systems so that services, cross-systems partnerships and practices can be improved ultimately leading to better outcomes for children and families. The initiative seeks to provide guidelines and best practices to assist state agencies, service providers and court officials working with adults and children at the intersection of the three systems. It is intended that the guidelines that result from the IDTA Initiative are adapted by local jurisdictions and will be recommended for use in all future initiatives and funding proposals to achieve better outcomes for children and families. There are four work groups comprising the Iowa IDTA Initiative. The scope of work assigned to each group is interrelated and has required regular coordination and communication.

The work-groups are:

1. Family Support Work group
2. House File 2310 Work group (specifically established in response to HF 2310 legislation)
3. Drug Testing Guidelines Work group
4. Multi-System Shared Values and Guiding Principles Work-group

III. House File 2310 Legislation

In 2008, the Iowa State Legislature passed House File Bill 2310. The purpose of the study is to identify effective means of reducing the incidence and impact of child abuse, including denial of critical care and interventions with families by the child welfare system that is wholly or partially caused by substance misuse, abuse, or dependency by a child's parent, guardian, custodian, or other person responsible for the child's care. The requirements under House File are to:

- Gather data identifying the prevalence of the presence of children in the household among adults receiving substance abuse evaluations using initial data collected at least three months of the fiscal year beginning July 1, 2008.
- Report whether or not substance abuse was a factor in the finding of abuse and report the prevalence of the finding using non-identifying information based on initial data collected at least three months of the fiscal year beginning July 1, 2008.
- Develop and implement a protocol in, or before July 1, 2009, to jointly address those child abuse cases that are wholly or partially caused by substance use disorders by the child's parent, guardian, custodian, or other person responsible for the child's care.
- Identify potential changes in Iowa's law that could encourage a child's parent, guardian, custodian, or other person responsible for the child's care to secure voluntary treatment for substance misuse, abuse, or dependency.
- Submit an initial report on or before December 15, 2009 to the Governor and the Standing Committees on Human Resources of the Senate and House of Representatives concerning the initial data collected, preliminary recommendations, and the status of the protocol implementation. A second report is due on or before December 15, 2010 regarding the data collect for a twelve month period.

IV. HF 2310 Work group

Process and Members

In September 2008, the Directors of the Iowa Department of Public Health and the Iowa Department of Human Services established a committee to respond to HF2310. Recognizing the need for an integrated system, DHS, IDPH, and the Supreme Court of Iowa, Children's Justice Initiative (CJI) agreed to work collaboratively as a part of the In-Depth Technical Assistance (IDTA) initiative to develop a coordinated response to House File 2310.

Under this directive, a core team was identified comprised of representatives from DHS, IDPH and judicial. The core team established a work-group committee consisting of representatives from DHS, IDPH, CJI, substance abuse treatment and prevention providers, the Iowa Behavioral Health Association, Magellan Behavioral Care, Prevent Child Abuse Iowa, physician representatives from the University of Iowa and Iowa Health System, a NCSACW consultant, and attorneys.

The initial meeting date of HF 2310 Work group was December 9th, 2008. The group subsequently met again on four more occasions; January 23rd, February 12th, March 24th and November 24, 2009 to review data, draft protocols and discuss Iowa law related to the HF 2310 product outcomes and deliverables. The following outcomes have been met:

- HF 2310 work group has adopted the mission, vision and guiding principles developed by the IDTA Initiative that works to improve policy and practices that lead to improved outcomes for children and families.
- HF 2310 work group has researched other state protocols for jointly addressing cases.

- DHS and IDPH have pulled data *(from July 1 – September 30, 2008)* related to HF2310, and have shared and discussed these findings with the core-team. The departments continue individually to collect and report data throughout fiscal year 2010 and will identify and share this data between both departments.
- HF 2310 work group has identified an attorney to review potential changes in Iowa law that could encourage a parent or caregiver to voluntarily seek substance abuse treatment.
- Products developed by IDPH and DHS and that are currently under practice review include:
    - A Substance Abuse Disorder Evaluation form that is sent to substance abuse providers that outlines required information to assist substance abuse providers in their assessment and collaboration with DHS and the family drug court.
    - A Multi-Party Release of Information form that is intended to increase collaboration, decrease duplication, and increase engagement among DHS, IDPH, and family drug courts for families entering the shared systems.
    - IDPH and DHS have developed and presented an initial cross-system training curricula.
    - Physician's Screening form has been developed for children in out–of-home settings in which DHS caseworkers coordinate with physicians to screen children for substance use.

V. Data Collection and Analysis

House File 2310 Legislation

House File 2310 Legislation mandates that the departments of public health and human services shall conduct a study involving the collection of information regarding the relationship between substance misuse, abuse, or dependency by a child's parent, guardian, custodian, or other person responsible for the child's care and child abuse. The data, activity, and information addressed by the study shall include but is not limited to all of the following: The department of human services shall include in the written assessment made for a child abuse report a determination as to whether or not substance abuse by the child's parent, guardian, custodian, or other person responsible for the child's care was a factor in the report and finding of abuse. The department shall provide non-identifying information concerning the prevalence of the determinations in child abuse assessments. The initial data collected shall cover at least three months of the fiscal year beginning July 1, 2008.

The Department of Human Services and Iowa Department of Public Health have gathered the data related to HF2310, from July 1 to September 30, 2008 and have shared and discussed these findings with the core-team. The departments will continue to individually collect and report data throughout fiscal year 2010 and will identify and share this data among departments on a consistent, continual basis. Following is the method and summary of findings to date regarding the data outcome results as collected by each department.

Iowa Department of Human Services

In conducting the data study the department determined that risk assessment scores would serve to reflect a correlation as to whether or not substance abuse by the child's parent, guardian, custodian, or other person responsible for the child's care was a factor in the report and finding of abuse. A stratified random sample was selected consisting of thirty (30) confirmed/founded CPS assessments from each of the eight (8) service areas from July-September 2008. DHS QA staff reviewed each sample assessment

and determined whether there was agreement between the data collected on the safety and risk assessment tools and the written information related to the finding contained within the CPS assessment. A standard data collection form was used to record information for each case in the sample. A total of 240 cases were reviewed and all percentages were based on the relationship to the total. Cases were weighted based on the population of the Service Area in which the incident occurred. The design margin of error for all figures reported in this study is ±5%.

In conducting this study, Risk Assessment scores were used to generate valid data regarding substance abuse as a factor in confirmed and founded protective assessments. It was found that in 30.1% of the total cases reviewed there was a relationship between the primary and/or secondary caregiver's substance abuse issue and the child protective assessment finding.

(The complete report entitled DHS Data Summary Report is located in the Appendix)

Iowa Department of Public Health

The Iowa Department of Public Health (IDPH) uses a web-based client data system entitled Iowa Service Management and Reporting Tool (I-SMART) that allows substance abuse treatment providers to enter client service data and supports IDPH in monitoring service trends and service system needs. I-SMART gathers TEDS (Treatment Encounter Data Set) information as required by the federal substance Abuse Prevention and Treatment Block Grant and includes the NOMs (National Outcome Measures) measures. Treatment providers enter demographic and clinical information into I-SMART. The system can also be used as an electronic clinical health record.

In regard to the HF 2310 study data collection I-SMART includes a question that asks "Are there children 17 years of age or younger living in the household". Reported data for clients receiving substance abuse services between July 1 and September 30th, 2008 is as follows: total number of clients assessed was 9,705; of this number 21.9% had children 17 or younger living in their household;

(The complete data summary entitled "House File 2310 Substance Abuse Data Summary-January 16, 2009", Iowa Department of Public Health" is located in the Appendix)

VI. Iowa Law Review

The HF 2310 work group identified attorney, Christine O'Connell Corken, First Assistant Dubuque County Attorney and Adjunct Professor, Criminal Law, Loras College, Dubuque, IA, to review potential changes in Iowa law that could encourage a parent or caregiver to voluntarily seek substance abuse treatment. Ms. Corken has extensive professional experience in issues related to families and children and currently serves as the Co-Chair of the Iowa Drug Endangered Children Alliance.

Current Iowa Law

Iowa Code Section 232.68, paragraph 1." Child" means any person under the age of eighteen years.

Iowa Code Section 232.68, paragraph 1. f. An illegal drug is present in a child's body as a direct and foreseeable consequence of the acts or omissions of the person responsible for the care of the child.

Under Iowa Law, the definition of child starts at birth, therefore, a positive test result obtained prior to the birth of a child shall not be used for criminal prosecution nor can it be used as a referral for child abuse allegations. Once a child is born, if a health practitioner discovers that the child has been born with evidence of exposure to cocaine, heroin, amphetamine, methamphetamine or other illegal drugs, that are not prescribed by the health practitioner, the practitioner is required to report any positive results to the Department of Human Services. The department will begin an assessment pursuant to Iowa law. If the presence of an illegal drug is found in a child's body as a direct and foreseeable consequence of someone's acts or omissions, the department must make a determination of "founded" child abuse, which results in the placement of the caretaker's name on the child abuse registry.

All states have laws defining by law what constitutes child abuse. There are state and federal reporting mandates but no federal law or standard that applies throughout the country. Individual states generally fall into three categories for enactment of these laws.

1) Some states allow for criminal prosecution upon positive findings of illegal substances found within a child either before or after birth. Iowa law prohibits this.

2) Some states mandate assessment by the Department of Human Services if the child tests positive at birth for the presence of illegal drugs. **Iowa falls within this category which is considered to be the model for future policy.**

3) Some states, a very small number, have enacted criminal statutes that provide for the prosecution of a parent for exposing the child to an illegal drug as evidenced by medically pertinent testing. Howe ver, if the parent complies with treatment, the criminal charge would be dismissed.

After extensive review of Iowa statutes, the committee recommends exploring current law to determine if alternatives are available for a pregnant woman who self reports illegal substance use and voluntarily receives and successfully completes services. If a child is born positive for illegal drugs an assessment will occur. Once the assessment is completed and it is determined that the child was exposed in utero to illegal drugs, current law requires automatic placement on the registry. Options might include placing the parent on a "confirmed" status rather than placing the mother automatically on the registry if the parent self reports illegal substance use prior to the birth of a child and successfully completes substance abuse treatment. This would provide an incentive for parents whose children test positive at birth to comply with the Department of Human Services in order to remain off the child abuse registry and potentially identifies children who are or may be potentially at risk of harm. This change would encourage parents to seek treatment, to establish a safe plan for their children, and to increase parental competency and self-sufficiency while protecting the children and holding the parents accountable for expectations of compliance with case plans set out by the Department without criminal intervention or placement on the child abuse registry.

VII. Protocol

Protocol Development

The co-occurrence of child maltreatment and substance use disorders demands immediate attention, and the highest standards of practice from the professionals who are responsible for assuring child safety and promoting family well-being. There is urgency to improving staff capacity to screen, assess, engage, and retain substance abusing families who are involved in the child welfare and dependency court systems. The Federal Adoption and Safe Families Act (ASFA) require that children have permanency in their lives. The law requires that children be reunited with parents, or permanency achieved, by termination of parental rights and adoption within specific timeframes. Collaboration amongst the three systems of DHS, IDPH and the court is imperative at the onset of a case to identify parental substance use disorders. Decisions regarding the effects on the child's well-being and the need for substance abuse treatment must occur immediately after a removal.

In the child welfare, substance abuse, and court triads, collaboration flows from the recognition that the agencies cannot achieve their outcomes *(safe children in stable homes with adults who are functioning well)* without the resources, expertise, and cooperation of the others. The literature on collaboration among the child welfare and substance abuse treatment systems highlights five major categories of barriers between the two systems that must be addressed before joint outcomes can be achieved (DDS, 1999; Young, Gardner, & Dennis, 1998);

1. Different definitions of who within the family is the client whether the child or the parent which results in different attitudes toward clients with alcohol and other drug (AOD)-related problems
2. Different training and education in recognizing and responding to AOD problems
3. Attitudes toward the other systems, founded in part on myths
4. Different timing factors in working with clients
5. Different funding streams and information systems mandated by those funding sources

Recognition of these barriers and in response to the mandated legislation, House File 2310 Work group developed a protocol based on a set of principles, standards and behaviors to guide daily practice when working with families who are involved in the child welfare, substance abuse treatment and dependency court systems. The protocol is in alignment and based on the National Center on Substance Abuse and Child Welfare's (NCSACW) framework of ten key elements of system linkages that are fundamental to improving outcomes and the long-term well being for families with substance use disorders who are involved in the child welfare services and dependency court system.

National Center on Substance Abuse and Child Welfare's (NCSACW) Framework

Key Element #1- Underlying Values and Principles of Collaborative Relationships

Underlying values should be addressed in developing collaborations because the partners are very likely to come to the table with different perspectives and assumptions about their agency's or the court's

values and mission and mandates. Unless these differences are addressed, the partners will be unable to reach agreement on issues.

HF 2310 Protocol-

- The protocol reflects the mission, vision and guiding principles of the IDTA Initiative[2] that was adopted by the HF2310 work group. Upon refinement, the protocol will be shared and promoted, trained on, and implemented statewide.
- The protocol promotes shared multi-system collaboration and promising/best practices for family-centered care.

Key Element #2- Daily Practice and Protocols in Client Screening and Assessment

Screening for substance use should be addressed by the collaborative since it is within these first contacts with clients that agencies must begin the process of determining what type of substance abuse problem- if any- the parent(s) have and what type of service they may need. Legal advocates for parents play a pivotal role in the process by either encouraging or discouraging their client from seeking services and being forthright during the evaluation.

HF 2310 Protocol-

- As part of the protocol DHS will implement practice guidance around substance abuse screening to ensure that treatment, when needed, emerges as a priority issue. All DHS caseworkers will receive training in Brief Screening and will utilize either the CAGE or the UNCOPE screening tools to identify the presence of parental substance use disorders.
- Caseworkers will also administer the Risk Assessment tool to identify the level of risk any substance use disorder may have on the family's functioning.
- Through the protocol, IDPH will implement practice guidance for all treatment agencies and treatment professionals to better identify clients at assessment who have a child welfare case and/or who are involved in juvenile court.
- The protocol asks that treatment agencies modify and enhance its screening and assessment process and encourages treatment staff to make immediate contact with the DHS caseworker and/or the Court.
- During a substance abuse evaluation, substance abuse providers will determine if a client is involved with DHS or the child welfare system, utilize the Substance Abuse Reporting system (I-SMART), contact the DHS worker, sign a multi-party release, participate in treatment planning and make recommendations

Key Element #3- Daily Practice for Client Engagement and Retention in Care

The Adoption and Safe Families Act (ASFA) and a child's developmental needs drive the need for keeping the parent(s) on track in meeting their parental responsibilities/goals while balancing the obstacles that generally confront substance dependent parents and their children. There are discrete roles and responsibilities that can be exercised by judicial officers to enhance parents' retention in treatment. Parent attorneys play a critical role in the messages that they give to clients about whether or not to engage in substance abuse treatment and/or other types of services. Treatment providers can ensure that they are utilizing client-centered, evidenced based practices such as the transtheoretical model of behavior change, motivational interviewing, and community reinforcement vouchers to engage and retain clients in services.

[2] A Statement of Multi-System Shared Values and Guiding Principles

HF 2310 Protocol-

- The protocol encourages practitioners from all three systems to participate in family team meetings, joint case planning services and/or telephonic collaboration between child welfare workers, substance abuse providers, courts, family members, and other stakeholders.

Key Element #4- Daily Practice in Services to Children of Substance Abusers

Services to children should be addressed by the multi-system collaborative. Providing services to parents alone ignores the effects that the substance abuse has had on the child(ren) and left unidentified and untreated can lead to future generations of substance abusers. Substance abuse services provided to families in the child welfare system should be provided using a family systems approach. Advocates for children have a role in ensuring that the special needs of children of substance abusing parents and/or caretakers are addressed by utilizing prevention and intervention strategies.

HF 2310 Protocol-

- The protocol supports practice guidelines that strive to ensure the specific needs of children are met as it adopts best practice strategies and interventions that promote and reflects the intent of the HF 2310 legislation:
    - Encourages participation of all providers at Family Team Meetings (FTM).
    - Utilizes the DHS Risk Assessment and Risk Reassessment Tools to identify the need for a substance abuse assessment.
    - Screens cases for possible substance use disorders, refers any potential cases to substance abuse providers, and works collaboratively across agencies.
    - Utilizes Early Access to address developmental delays.
    - Drug Courts
    - CRAFT Tool was used for children to assess for any substance abuse issues.
- The protocol asks treatment agencies to identify the presence of children in their treatment caseload and the need for screening and assessment of those children (through direct service or referral) for the impact of their parents' substance abuse.

Key Element #5 Joint Accountability and Shared Outcomes

This element should be addressed by the collaborative because jointly developed outcomes are critical to demonstrate that the collaborative has achieved interagency agreement on desired results. Without such an agreement, each system/partner is likely to continue measuring its own progress as it always has and without respect to the other systems.

HF 2310 Protocol-

- The protocol encourages the sharing of outcomes between agencies for children and family.
- The protocol promotes and endorses shared values and guiding principles across agencies.
- Common language and understanding across disciplines are supported within the protocol.
- Collaborative efforts are viewed as essential in the protocol to address the needs and services for children and families experiencing substance use disorders.

Key Element #6- Information Sharing and Data Systems

Shared data is a prerequisite for joint accountability. Joint information systems form the basis for communicating across systems and must be used to track the progress of the collaborative. Without effective communication and sharing of information across systems, the collaborative will be left without the guideposts to gauge its program's effectiveness.

HF 2310 Protocol-

- A Multi-Party Release of Information form was developed to be initiated by whichever system has access to the client at the time it becomes apparent that the client is involved with both systems.
- Each department has captured initial data for July through September of 2008 and will utilize individual data systems in an ongoing basis to collaborate toward earlier identification of shared clients.
- Under the protocol, substance abuse treatment agency staff will ask if there is DHS or child welfare involvement, if yes, then coordination of care with the clients, caseworker, court officer and other involved stakeholders will occur.
- DHS will send a Substance Use Disorder Evaluation Referral form with the Multi-Party Release to substance abuse treatment provider.
- The protocol supports collaboration between providers in order to keep each other updated on an ongoing basis regarding client progress, relapse planning and discharge planning.

Key Element #7- Budgeting and Program Sustainability

Tapping the full range of funding sources available to the state or a community through multiple strategies is imperative for the sustainability of services. Results drive the allocation of resources; therefore services should produce positive outcomes and improve the lives of children and families.

HF 2310 Protocol-

- Within the intent of the mission and vision of the protocol the Departments and the Court will strengthen relationships between stakeholders and promote and maximize the use of existing programs and resources including:
    - Drug Endangered Children
    - State Court Improvement Project
- The protocol promotes shared outcomes that require increased emphasis, including the on-going monitoring and reporting, of results-driven outcomes.

Key Element #8- Training and Staff Development

Cross-systems training builds respect and operational knowledge that fosters a seamless system of care for families and imparts practical guidance for dealing with differences of opinion without damaging the collaborative process. Decisions regarding child safety and optimum family health are best made by people who draw on the expertise of multiple perspectives. Cross training efforts that are collaborative

and are provided at all levels of policy, administrative, management and line-staff promotes improved outcomes for children and families.

HF 2310 Protocol-

- Training for the protocol requires a cross-systems training regimen that leverages the use of existing resources including department curriculum combined with an NCSACW On-Line Training that promotes a cross-system understanding of substance abuse, child welfare and the judicial system
- The protocol ensures that all staff participates in the cross-systems training.
- The protocol encourages collaborative outreach and joint partnering and planning within local communities to identify resources, build relationships, and achieve shared outcomes.

Key Elements #9 and 10- Working with Other Agencies and the Community

Substance abusing families who are involved with child welfare and the dependency court require assistance from services in addition to treatment to address the multitude of complex issues impeding the functioning of a healthy family system. In particular, mental health, domestic violence, primary health, housing, and employment-related services are needed partners in the multi-systemic collaboration.

HF 2310 Protocol-

- The protocol actively promotes the development of strategic partnerships with community-based services and supports through:
    - Ensuring that relevant service providers are involved with Family Team Meetings
    - Joint case planning between agencies
    - Ongoing, in person and/or telephonic, communication between agencies
    - Joint accountability through shared outcomes

VII. Pilot Project

DHS, IDPH, and the Supreme Court of Iowa's Children's Justice Initiative (CJI) made a collaborative decision to pilot the HF2310 project in two counties. Wapello and Scott counties were chosen as pilot sites as each county has established collaborative, partnerships between DHS, substance abuse treatment providers, and family drug courts. The 90-day pilot projects were implemented on July 1, 2009.

Participants included Department of Human Services (DHS) caseworkers and substance abuse treatment providers within each of these counties. Following is a description of the substance abuse treatment providers in each of the pilots:

Wapello County

- First Resources- A private, non-profit human service corporation offering a full range of programs servicing people with disabilities, mental health services, children and families in need, and drug and alcohol counseling for adults .

- Family Recovery Center- An entity of Ottumwa Regional Medical center that provides treatment to adults, age 18 and older, who suffer from illness of addiction to alcohol and drugs. The addiction program is based on abstinence through the 12 steps of Alcoholics Anonymous.
- Southern Iowa Economic Development Association (SIEDA) - A community agency which provides substance abuse treatment and evaluation services.

Scott County

- Center for Alcohol and Drug Services (CADS) – A non-profit organization established to provide substance abuse prevention, assessment, treatment, and referral services for individuals, groups, and organizations in eastern Iowa and western Illinois, through a combination of private and public funds

Joint Training

- Joint training sessions were held at each of the pilot sites to introduce the protocol and to promote joint accountability and shared outcomes among the agencies. A cross-system, multi-disciplinary team approach is critical as each agency shares a role in achieving safety, permanency and well-being outcomes for children and families with substance use disorders.

- Participants at the pilot sites were also asked to take an online education course offered by the NCSACW to better understand their counterpart's practices and approaches to substance use disorder in child welfare cases. On-line substance abuse training was offered for DHS workers, while substance abuse treatment staff were asked to take the child welfare training.

Screening and Assessment

- Within the joint protocol, screening and assessment duties for both DHS staff and substance abuse providers are outlined. The proposed steps, tools, and designated forms are intended to decrease the time providers make contact with DHS clients who were being referred:

    - In child abuse assessments and throughout the life of the case DHS caseworkers assess the caregivers for substance abuse using either the **CAGE or UNCOPE** screening tools. These tools are not diagnostic but provide a baseline of information regarding a possible substance use disorder.

    - In addition to the CAGE or UNCOPE tool, DHS case workers administer the **Family Risk Assessment tool**. Risk assessment focuses on the probability of future maltreatment and in substance abuse cases highlights the effects of substance use disorders in relation to child maltreatment and informs decisions regarding services or need for removal of the child. The Risk Reassessment tool would be utilized in ongoing cases.

    - When a substance abuse disorder is identified by DHS, the caregiver is asked to sign a **Multi-Party Release of Information form** and is referred to a substance abuse treatment program for evaluation. The A Multi-Party Release of Information form is used to facilitate communication across both systems and with any other involved parties, such as Family Drug Court, family support programs, and mental health services. The Multi-Party Release of Information is completed and initiated by either party based on who first identified that the client was involved with both the child welfare and substance abuse treatment systems.

- DHS caseworkers will coordinate a physician screening of risk for substances as part of the foster care physical when a child is in out-of-home care. The Physicians are asked to complete a **Physician Screening** form indicating when a child should be referred for further evaluation.

Joint Service Collaboration

- At the time of the referral the caseworker completes a **Substance Abuse Disorder Evaluation Referral** form providing the substance abuse treatment worker with information regarding the purpose of the referral.
- During a substance treatment evaluation, treatment staff identifies any involvement the client may have with DHS and/or court services. Clients are asked the age of the children involved, the referral source, and the type, if any, of DHS or court involvement. If DHS is involved, clients are asked to provide caseworker contact information upon which treatment staff contact the caseworker to initiate care coordination.
- To create a cross-system multi-disciplinary team approach, DHS caseworkers and substance abuse treatment staff must engage in **joint service collaboration. S**trategies and services within the **DHS Family Case Plans** and the **Substance Abuse Treatment and Relapse Prevention Plans** reflect and support each other. Barriers to the family's success are identified and resolved with respect to the timetables that each system must operate within.
- Additional collaborative responsibilities between DHS caseworkers and substance abuse treatment staff include participation in Family Team Meetings, ongoing joint case planning, and telephonic case coordination on a consistent basis.

Services to Children

- DHS assesses any child substance abuse concerns using the **CRAFT,** a screening tool which is specific to children. Children who scored positive on this tool are referred to a substance abuse treatment program for evaluation.
- DHS caseworkers refer children under the age of three who have been a victim of abuse or have an assessed need to Early Access for developmental screening.
- For children in out–of-home settings, DHS caseworkers coordinate with physicians to screen children for substance use. Physicians are asked to complete a **Physician Screening Form** indicating when a child should be referred for further evaluation. This screening process is viewed as a part of the foster care physical required of children who are in out-of-home care settings.

VIII. Protocol Review

Data was collected by the four substance abuse treatment providers during the pilot project. Data was collected in regard to:

- Children 17 or younger living in the household
- The number of children who spent last 6 months living with client
- The number of children living out of home under a protective order
- Attendance at family team meetings and involvement with DHS child welfare

Analysis of 57 data outcome forms indicated that substance abuse providers were: (1) in 100% of cases, better able to identify children involved with DHS child welfare, (2) in 100% of cases, better able to ask the client for caseworker contact information (3)in 98% of cases, obtained a multi-party release , (4) in 95% of cases, better able to contact DHS workers to initiate care coordination (5) and in .05% of cases, able to attend family team meetings.

Survey and Focus Groups

At the conclusion of the pilot project a survey was conducted and focus groups were held for the DHS caseworkers and substance abuse treatment providers who participated in the pilot project. The purpose of the survey was to better understand the experiences of the participants and to assist DHS and IDPH in identifying the strengths of the protocol, any concerns or issues related to joint service planning, and the timing issues related to the evaluation and services to families experiencing substance use disorders. Questions on the survey covered the preferences, usefulness, and effectiveness of the proposed screening tools. Participants were asked if the forms proved helpful and if they were instrumental in reducing barriers and facilitating communication and collaboration between providers and across systems. The survey also questioned if the training was found to be helpful and relevant, and if the use of family team meetings and telephonic case coordination were effective in creating a cross-system multi-disciplinary approach to reach shared outcomes. The group was also questioned if the caregiver referred from DHS was served more quickly than other self referred clients. The focus groups that followed the survey provided a more in-depth review of the survey responses and the processes involved.

HF 2310 Survey and Focus Group Findings

- The CRAFT, CAGE and UNCOPE tools were useful in assessing both children and adults. The UNCOPE questions were a good way to start the conversation about substance use/abuse if the subject had not been previously addressed. Both tools provided more consistency and structure in deciding which families needed a substance abuse referral.
- Early Access referrals were made on cases they would have normally done so. The protocol did not influence their decision making process.
- Physicians that were asked to complete the physician screening question on children placed out of the home were cooperative in doing so and found it helpful. Workers recommended it become a regular part of the foster care physical for all cases.
- Time from point of DHS referral to having a client seen by a substance abuse treatment provider did not decrease. The universal release that was developed for the protocol was not seen as useful. Both agencies continued to complete their own releases anyway. Clients revoked releases upon seeing the substance abuse provider therefore not allowing any information to be shared. In one area the substance abuse treatment provider does not, by policy, contact the referral source until the evaluation has been completed. DHS and the substance abuse provider felt that communication could be enhanced. Substance abuse treatment providers have indicated they cannot prioritize DHS referrals over others. Both agencies felt a "check-in" point at the end of each month would have been helpful to identify barriers/issues sooner instead of waiting to address them at the end of the pilot.

- The substance abuse evaluation form had a mixture of findings. While it may contain good information from DHS that a client may not self-disclose, it was not consistently used. Further training on the evaluation could address this issue. Workers and providers felt a phone conversation about the client was more helpful. However, these did not occur consistently either.
- Both DHS and substance abuse treatment provider staff reported the on-line training sessions were very helpful. Workers learned more about the partner agencies goals, processes and procedures.
- Family Team Meetings were not attended at a higher rate by substance abuse treatment providers than in situations without the protocol. Joint planning for cases with mutual clients was done on the phone or by electronic communication.
- Overall, the protocol was seen has helpful in identifying clients for referral for substance abuse evaluations. Being a part of a joint protocol decreased barriers between agencies and increased communication. Examples built into the protocol about how to partner within agencies was seen as helpful and improved outcomes for families.

In analyzing the findings, it was found that they are reflective of current literature regarding collaboration among the child welfare and the substance abuse treatment system. The major barriers around shared definitions, attitudes, differences in training and education, timing and funding, and information systems discussed previously in this report were found to exist during the pilot project. Based on the findings it appears that these areas will continue to be areas of concern and will need to be addressed further at both a statewide and a community level.

IX. Recommendations

- Implementation of a 2nd pilot project at two non-drug court sites based on lessons learned from recent the past pilot to better train, support, oversee, and evaluate the project.
- Continued exploration of potential law changes to determine if alternatives are available for a pregnant woman who self reports illegal substance use and voluntarily receives and successfully completes services.

X. Conclusion

Safety and permanency are the birthright of every child in Iowa. The vision is that children in the State of Iowa grow up in safe, nurturing, and permanent families, and within their birth family when possible, or, if not, with another permanent family. As stated earlier, no single agency or court has the authority, capacity or skills to respond to the array of challenges faced by these families, but collectively, well – informed professionals can bring capabilities and skills together to help address the problem. When leaders have a common vision, follow joint policies and engage collaborative front line practices, it creates a positive work environment and the expectation that the professionals involved will coordinate

with colleagues from other systems in decisions that affect a family's stability and recovery when faced with a substance abuse.

Together, the departments and the court are committed to developing and implementing a statewide coordinated plan to work with families with substance use disorder in the child welfare and juvenile court systems. Since the completion of the pilot and based upon review of the results, it is recommended that another pilot project be implemented in two counties where there are no drug courts. This will provide the larger knowledge base needed to analyze and share the data, study law options, and refine the approach to allow for better decision making in collectively responding to the complex needs of families that present with substance use disorder and maltreatment issues and to carry the initiative statewide. The added knowledge will impact policy decisions and ultimately the development and array of services that focus on prevention, treatment, and support across the system of care to be offered to children and families who are at risk.

XI. Appendix

- DHS and IDPH Joint Protocol
- Substance Use Disorder Evaluation Referral Form
- Multi-Party Release; Substance Abuse Agency/ Child Welfare Consent Form
- IDPH letter to Licensed Substance Abuse Programs
- DHS Data Summary Report
- House File 2310 Substance Abuse Data Summary – January 16, 2009 (Iowa Department of Public Health)



DHS ce Use Disorde

Brief Summary of Findings.pdf

HF2310 IDPH Data Jan09.doc



Protocol Ltr May1309.doc

HF2310 Party Consent

JointProtocol June1509.doc

DHS and IDPH Joint Protocol

Working with Families in the Child Welfare System related to Parent or Caregiver Substance Abuse

Introduction

During its 2008 session, the Iowa Legislature passed House File 2310 which directed the Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH) to reduce child abuse related to parent or caregiver substance abuse. In implementing HF 2310, the Departments are to:

- determine the prevalence of substance use by a child's parent or caregiver as a factor in a child abuse report and the finding of child abuse
- identify potential changes that could encourage a parent or caregiver to voluntarily seek substance abuse treatment
- identify the prevalence of the presence of children in the households of adults receiving a substance abuse evaluation
- implement a joint protocol by July 1, 2009 to address child abuse cases related to parent or caregiver substance abuse.

Background

In November 2007, DHS, IDPH, and the Iowa Judicial Branch implemented a partnership to address the needs of families involved with the child welfare, court, and substance abuse service systems. Nationally, substance abuse and child maltreatment are two of our most pressing social problems and are often intertwined. In Iowa, 70-80% of open child welfare cases are related to substance abuse and 22% of clients receiving substance abuse services report a DHS or child welfare connection.

Through a wide variety of stakeholders statewide and an In-Depth Technical Assistance grant from the National Center for Substance Abuse and Child Welfare (NCSACW), the DHS, IDPH and Judicial Branch partnership is enhancing cross-system practices to improve outcomes for our shared families.

Protocol Development

The House File 2310 (HF 2310) work group was established for the specific purpose of developing a joint protocol between IDPH and DHS to address child abuse cases related to parent or caregiver substance abuse.

In responding to the House File Bill, the workgroup developed a written document that puts forth a set of principles, standards, and behaviors to guide daily practice. This protocol is established within the National Center on Substance Abuse and Child Welfare's (NCSACW) framework for collaboration. The framework consists of ten critical elements of system linkage that are fundamental to improving outcomes and long-term well-being for families with substance use disorders involved in the child welfare and dependency court system protocols.

Joint Protocol - Child Welfare and Substance Abuse

A. Screening and Assessment

1. Protocol: DHS Caseworkers - Screen for Substance Abuse

In child abuse assessments or child welfare cases, DHS caseworkers will:

a. Assess parents or primary and secondary caregivers for substance abuse problems.
b. Use the CAGE or UNCOPE to screen parents or primary and secondary caregivers for substance abuse problems in any instances where doubt or uncertainty remain.
c. Use the Family Risk Assessment to screen parents or primary and secondary caregivers for substance abuse problems.

Action →	**If a possible substance abuse problem is identified, the DHS caseworker will:** **1) ask the caregiver to sign a multi-party release** **2) refer the caregiver to a substance abuse treatment program.** **3) send substance abuse disorder evaluation to treatment program.**

2. Protocol: Substance Abuse Treatment Staff - Identify DHS Child Welfare Involvement

In substance abuse evaluations, treatment staff will ask the client the following questions about children, referral source, and court involvement:

a. Are there children 17 years of age or younger living in the household? (I-SMART admission question #41)
b. Number of children who spent last 6 months living with client? (question #42)
c. Children living with someone else due to protective order? (question #43)
d. Was the referral source DHS-Child Abuse, DHS-Drug Endangered Child, DHS-Child Welfare, or DHS-Other? (question #14)

Action →	**If involvement with DHS child welfare is identified, substance abuse treatment staff will:** **1) ask the client for caseworker contact information** **2) ask the client to sign a multi-party release** **3) contact the DHS caseworker to initiate care coordination.**

B. Information Sharing

1. Protocol: DHS Caseworkers and Substance Abuse Treatment Staff - Multi-System Release of Information

DHS caseworkers and substance abuse treatment staff will use a multi-system release of information to facilitate communication across both systems and with other involved parties such as Family Drug Court, family supports, and mental health services.

Action →	**The multi-system release of information will be initiated by the DHS caseworker or by substance abuse treatment staff based on who first identifies that the client is involved with both the child welfare and substance abuse treatment systems.**

2. **Protocol: DHS Caseworkers - Substance Abuse Treatment Referrals**

Action →	**DHS caseworkers will send the Substance Use Disorder Evaluation Referral form to the treatment program at the time of the referral for substance abuse evaluation.**

C. Joint Accountability and Shared Outcomes

1. **Protocol: DHS Caseworkers - Substance Abuse Training**

Action →	**DHS caseworkers will take the on-line substance abuse training available through the NCSACW website.**

2. **Protocol: Substance Abuse Treatment Staff - Child Welfare Training**

Action →	**Substance abuse treatment staff will take the on-line child welfare training available through the NCSACW website.**

3. **Protocol: DHS Caseworkers and Substance Abuse Treatment Staff - Service Planning**

DHS caseworkers and substance abuse treatment staff will initiate joint service planning. DHS case plans will support the substance abuse treatment and relapse prevention plans and substance abuse treatment and relapse prevention plans will support the DHS case plan. Barriers to the family's success will be identified and resolved.

Action →	**DHS caseworkers and substance abuse treatment staff will promote and participate in Family Team Meetings, joint case planning, and telephonic care coordination.**

D. Services to Children of Substance Abusers

1. **Protocol: DHS Caseworkers - Early Access**

Action →	**DHS caseworkers will refer parents to Early Access to address developmental delays in children under the age of three who have been a victim of abuse or have an assessed need for screening.**

2. **Protocol: DHS Caseworkers - Risk for Substances Screening**

Action	
Foster Care →	**DHS caseworkers will coordinate physician screening of risk for substances as part of the foster care physical when children are in out-of-home care.**

3. Protocol: DHS Caseworkers - Substance Use Screening

Action →	**DHS caseworkers will:** **1) Assess child substance abuse concern when assessing needs of a child.** **2) Use the CRAFFT to screen for substance abuse in any instances where doubt or uncertainty remains.** **3) Refer a child who screens positive to a substance abuse treatment program for evaluation.**

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES J. KROGMEIER, DIRECTOR

Substance Use Disorder Evaluation Referral Form

DHS Worker: _____
Date: _____
Mailing Address: _____
Phone#: _____ **EXT.** _____ **Email:** _____ **FAX:** _____
Name of the referred person: _____
Client Contact Information: _____

Release signed on (date) _____ Copy attached☐ or mailed on (date) _____

Purposes for which the evaluation will be used: _____

Why is the referral being made at this time/Referral Questions? _____

Current substance misuse, abuse, or dependency concerns: _____

Dates/Results of any drug testing completed prior to referral: yes☐ no☐

_____

Other agencies currently involved with client: yes ☐ no☐

_____

Past involvement of the Iowa Department of Human Services: yes☐ no☐

_____

Past Involvement with the Juvenile Court: yes☐ no☐

_____

Known past history with substance misuse, abuse, or dependency: yes☐ no☐

_____

Past history of treatment experiences with mental health and/or substance abuse: yes☐ no☐

_____

Any other information that is felt to be beneficial in completion of an evaluation: _____

Summary of Findings

Validation Of Family Risk And Safety Assessment Tools As An Indicator Of The Role Of Caretaker Substance Abuse As A Factor In Child Abuse

A stratified random sample was selected consisting of thirty (30) confirmed/founded CPS assessments from each of the eight (8) service areas from July-September 2008. DHS QA staff read each sampled assessment and determined whether there is agreement between the data collected on the safety and risk assessment tools and the written information related to the finding contained within the CPS assessment. A standard data collection form was used to record information for each case in the sample. A total of 240 cases were reviewed and all percentages are based on the relationship to that total; cases were weighted based on the population of the service area in which the incident occurred. The design margin of error for all figures reported in this study is ±5%. The following reflects the information gathered during this study:

1. Risk/Safety Assessment

A. Does the information collected using the Safety Assessment tool accurately reflect the information about caretaker substance abuse indicated in the CPS assessment? If not, was that information "knowable" within the 24-hour timeframe for completion of the safety assessment?

- In 90.3% of the 240 cases reviewed, the safety assessment substance abuse score accurately reflected the information contained in the CPS assessment;
    - In 6.8% of the total cases, the safety assessment was not scored accurate although substance abuse information was available ("knowable") at the time the assessment was completed;
    - Of the 9.7% of cases that were not scored accurately, it was two times more likely to reflect a false negative – scored that there is not a substance abuse issue when, in fact, there is – than a false positive.

B. Does the information collected on the Risk Assessment tool (Question N8: "Primary caregiver has a substance abuse problem") accurately reflect the information about primary caretaker substance abuse indicated in the CPS assessment?

- In 93% of the cases reviewed, the risk assessment accurately reflected the information contained in the CPS assessment;
    - In the 7% of cases that did not accurately reflect the information from the CPS assessment, there was an even split between false negatives and false positives.

C. Does the information collected on the Risk Assessment tool (Question A10: "Secondary caregiver has a substance abuse problem") accurately reflect the information about caretaker substance abuse indicated in the CPS assessment?

- In 92.8% of the total cases reviewed, the risk assessment score accurately reflected the written CPS assessment information;
    - In the remaining 7.2% of the cases reviewed, scores were inconsistent with the written assessment; errors reflected a false positive in 4.6% of the 240 cases reviewed.

2. Was there any relationship between the primary/secondary caregivers' SA issue and the finding on the CPS assessment?

- Substance abuse was determined to not be an issue for 74% of the primary caretakers in the cases reviewed; substance abuse was determined to not be an issue for 82% of secondary caregivers.
- In 24.5% of the total cases, the **primary** caregiver's substance abuse issue impacted the child abuse finding;
- In 15.2% of the total cases, the **secondary** caregiver's substance abuse issue impacted the child abuse finding;
- In 9.6% of the total cases, substance abuse was identified as an issue for **both** primary and secondary caregivers.
- In 30.1% of the total cases reviewed, there was a relationship between the primary **and/or** secondary caregiver's substance abuse issue and the child protective assessment finding.

3. Most common substances abused are consistent across primary and secondary caregivers (categories are not exclusive):

Substance	Primary Caregiver Use	Secondary Caregiver Use	Use by either Caregiver
Alcohol	12.3%	9.2%	17.9%
Marijuana	8.3%	5.5%	9.5%
Methamphetamine	7%	2.5%	7.9%
Cocaine	2.3%	1%	2.3%
Prescription Drugs	0.3%	0.9%	1.2%
Other	1.4%	1.4%	2.5%
No Substance Abuse Issue	74%	82%	67.7%

Conclusions:

- **Substance abuse on the part of either the primary or secondary caregiver was a factor in 30.1% of the CPS assessments reviewed;**
- **Risk Assessment scores are a more accurate and valid measure of the role of Substance Abuse in abuse findings (93% of cases reviewed) than the Safety Assessment scores (90.3% of cases reviewed);**
- **Risk Assessment scores are slightly more likely to indicate a substance abuse problem when there is not actually an issue (4.6% of cases reviewed reflect false positives);**
- **Risk Assessment scores can be used to generate valid data regarding substance abuse as a factor in confirmed and founded protective assessments.**

Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Division of Behavioral Health: www.idph.state.ia.us/bh

House File 2310 Substance Abuse Data Summary - January 16, 2009

Background and Funding

The IDPH Division of Behavioral Health is responsible for licensing and regulating substance abuse treatment programs in Iowa. The Division also administers the federal block grant and state appropriations that fund substance abuse treatment for Iowans without insurance or Medicaid (Title 19) or other resources to pay for services. IDPH funding is a set amount of money every year, determined by the U.S. and Iowa legislatures. Prospective clients access IDPH-funded services by going to their local IDPH-funded provider for an assessment and treatment recommendation. Providers are required to assess a client co-pay for IDPH-funded services, using a sliding fee scale based on client ability to pay. IDPH funding must be the funding of last resort.

Since 1995, IDPH-funded substance abuse services have been part of the Iowa Plan for Behavioral Health. Medicaid-funded mental health and substance abuse services are also part of the Iowa Plan. Iowa Pan substance abuse covered services include:

- Assessment
- multiple Outpatient levels of care
- Halfway House
- Residential treatment
- * substance abuse PMIC
- * Inpatient hospitalization
- * Detoxification

(* Services covered by Medicaid; not covered by IDPH funding)

For provision of Medicaid-funded services, the Iowa Plan contractor, Magellan Behavioral Health, contracts with all licensed substance abuse treatment programs. For IDPH-funded services, Magellan competitively procures and contracts with a limited panel of substance abuse treatment programs.

IDPH Substance Abuse Data System

IDPH has a web-based client data system entitled I-SMART (Iowa Service Management and Reporting Tool) that allows IDPH, Magellan, and Iowa Plan substance abuse treatment providers to administer and report services. I-SMART gathers TEDS (Treatment Encounter Data Set) information as required by the federal block grant and includes NOMs (National Outcome Measures) elements. Providers enter demographic and clinical information into I-SMART and can also use it as their clinical record system. I-SMART has a question on clients with children aged 17 and younger living with them. Reported data for that question for clients receiving substance abuse services between July 1 and September 30, 2008 are noted in the table below:

I-SMART Data on Substance Abuse Clients with Children ≤17yo Living with Client July 1-September 30, 2008			
Clients Receiving Assessment Only		Clients in Treatment	
Total # Clients	# Clients w/Children	Total # Clients	# Clients w/Children
9,705	2,124 (21.9%)	18,445	4,133 (22.4%)

Note: I-SMART data can be sorted in multiple ways including:

- client age and gender
- referral source, e.g. DHS
- substance(s) used, e.g. Methamphetamine
- treatment funding source, e.g. IDPH funding, Medicaid

Contact Bob Kerksieck at RKersie@idph.state.ia.us or Michele Tilotta at MTillota@idph.state.ia.us

Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Thomas Newton, MPP, REHS
Director

Chester J. Culver
Governor

Patty Judge
Lt. Governor

July 1, 2009

TO: Licensed Substance Abuse Programs
FROM: Kathy Stone, Division of Behavioral Health Director

In November 2007, IDPH, the Department of Human Services (DHS), and the Iowa Judicial Branch Children's Justice Initiative implemented a partnership to address the needs of families involved with the child welfare, court, and substance abuse service systems. Substance abuse and child maltreatment are two of our most pressing social problems and are often intertwined. In Iowa, 70-80% of open child welfare cases are related to substance abuse. Through a wide variety of stakeholders statewide and an In-Depth Technical Assistance grant from the National Center for Substance Abuse and Child Welfare, the partnership is enhancing cross-system practices to improve outcomes for our shared families.

In 2008, through House File 2310, the Iowa Legislature directed IDPH and DHS to reduce child abuse related to parent or caregiver substance abuse. In implementing HF 2310, the Departments are to:

→ ***in child abuse assessments*** - determine the prevalence of substance use by the child's parent or caregiver as a factor in the child abuse report and the finding of child abuse

→ ***in Iowa law*** - identify potential changes that could encourage a parent or caregiver to voluntarily seek substance abuse treatment

→ ***in substance abuse evaluations*** - identify the prevalence of the presence of children in the households of adults receiving an evaluation

- Based on data reported by providers, IDPH determined that approximately 22% of clients receiving substance abuse services report having children 17 years or younger living in the home and 22% report a DHS or child welfare connection.

→ ***jointly implement a protocol*** by July 1, 2009 to address child abuse cases related to parent or caregiver substance abuse.

The following are elements of our shared protocol for which we are asking your commitment:

1. During a substance abuse evaluation, ask the client if there are children 17 years of age or younger living in the household. (I-SMART admission form question #41).
   If the answer to question #41 is yes, ask:
   a) question #42 - "# of children spent last 6 months living with client" and
   b) question #43 - "Are children living with someone else due to protective order"

2. During a substance abuse evaluation, determine if the client is involved with DHS or the child welfare system by asking about referral sources as listed in I-SMART admission form question #14: DHS-Child Abuse, DHS-Drug Endangered Child, DHS-Child Welfare, or DHS-Other.

3. If a client answers yes to question #41 or #43 or if the client is referred by DHS as listed in question #14, ask if the client has a caseworker. If yes, request the DHS caseworker's contact information and ask the client to sign a multi-party release (attached) allowing you to talk with the caseworker and other involved parties like Family Drug Court, Family Supports, mental health providers, etc. to coordinate care.

4. Contact the DHS caseworker to initiate your participation in care coordination. (Reminder: participation in Family Team Meetings for Medicaid enrollees can be authorized and reimbursed through the Iowa Plan.)

5. As part of your participation in ongoing care coordination, plan to share pertinent information on treatment planning and progress as well as discharge summaries, relapse prevention and continuing care plans, and recommendations for further treatment or other services.

Contact Michele Tilotta with any questions at MTilotta@idph.state.ia.us or 515-281-4816. Additional resources are posted on the IDPH website.

As always, thank you for your continued efforts on behalf of Iowa substance abuse clients and their families.

Attachment: Multi-Party Release of Information/Authorization to Disclose

SUBSTANCE ABUSE AGENCY / CHILD WELFARE CONSENT FORM

CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG TREATMENT INFORMATION TO AND FROM CHILD WELFARE AGENCY (AND COURT AND ATTORNEY (S), WHERE NECESSARY)

I, _____ authorize
(Name of patient)

(1) _____
(Substance Abuse Treatment Agency)

(2) Iowa Dept. of Human Services Case Workers & Case Worker Supervisors
(Name of the child welfare agency)

(3) _____
(Name of the appropriate court)

(4) _____
(Name of the patient's attorney)

(5) _____
(Name of child(ren)'s attorney (law guardian(s))

(6) _____
(Other)

to communicate with and disclose to one another the following information:
[initial each category that applies]

_____ my name and other personal identifying information;
_____ my status as a patient in [alcohol and/or drug] treatment;
_____ initial evaluation;
_____ date of admission;
_____ assessment results and history;
_____ summary of treatment plan, progress and compliance;
_____ attendance;
_____ urinalysis results;
_____ changes in address, household composition or personal relationships that could result in child neglect/abuse or domestic violence;
_____ observations of visitation of child(ren);
_____ discharge plan; date of discharge and discharge status; and (optional)
_____ other: _____

The purpose of the disclosures authorized in this consent is to:
provide DHS, the substance abuse treatment agency, court, the child's attorney and my attorney with the information they need to determine whether I have made sufficient progress in treatment.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(1) *Six months after termination of the child abuse/neglect case and/or investigation against me.*

OR

(2) *Specify other date* _____

Dated: _____ _____
Signature of patient

Dated: _____ _____
Signature of patient (Not necessarily for substance abuse treatment)

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREAMTMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules including (42 CRF Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Public Law 104-191. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.